MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

December 5, 2007
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, December 5, 2007 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Charlie Dannelly, and Vernon Malone, and Representatives Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, Carolyn Justus, and Fred Steen. Advisory members, Senator Larry Shaw and Representatives Van Braxton and William Brisson were present. Also in attendance were Representatives Pat Hurley, Deborah Ross, and Jennifer Weiss.

Kory Goldsmith, Shawn Parker, Susan Barham, Andrea Poole, Melanie Bush, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She introduced Denise Harb who recently joined the Fiscal Research Division. Representative Insko asked for a motion to approve the minutes from the November 15, 2007 meeting. Senator Nesbitt made the motion and the minutes were approved.

Representative Insko asked Grayce Crockett, Director of the Mecklenburg Local Management Entity (LME), to report on the Mecklenburg hospital pilot project, and on the plans to reduce bed days at Broughton hospital. (See Attachment No. 2) Ms. Crockett said Mecklenburg's relationship with Carolina's Health Care was the core of their crisis continuum. She said that Carolina's Health Care operates a 24/7 dedicated psychiatric emergency room and 66 inpatient beds. The facility allows Mecklenburg to divert consumers from Broughton hospital. Ms. Crockett explained that the growth in population in Mecklenburg County continued to be a challenge. She said that over 200 psychiatric beds had been lost since 2000 leaving only Carolina's Medical Center (CMC) and Presbyterian hospital with beds. The fact that the beds are full can impact diversion from Broughton hospital as Mecklenburg moves forward. Ms. Crockett explained the proposed pilot plan, and Mecklenburg's plans to expand local capacity. She said Mecklenburg's goal was to reduce bed days by 350 in 2008 and an additional 700 bed days in 2009. In order for Mecklenburg to successfully reduce bed days, the LME requested $204,820 in 2008, and $405,240 in 2009.

Other points raised in Ms. Crockett's presentation included:

- Broughton hospital received approximately 40 admissions per month from the Mecklenburg LME. The majority of the admissions were for 7 days. She said that the lack of local capacity was the reason for those admissions. She explained that Presbyterian hospital diverted patients to Broughton due to lack of capacity.
- 45% of the Mecklenburg LME budget comes from county funds and the rest from State and Medicaid funds. $39 million is budgeted in local funding this year.
- 80-90 additional beds would be needed over the next 5 years. $50 million is needed to build those additional psychiatric beds.
- Keeping consumers in the community could be more expensive because a wider variety of local resources must be utilized to keep individuals out of a secure setting.
- Finding secure beds in the community for adolescents is increasingly more difficult.

The Division was asked to get the cost of one bed day. Ms. Wainwright said she would get the information. The Division was also asked to provide data showing the types of treatments provided to those discharged, where they are now, and what type of follow-up is being provided now.

It was suggested that other LMEs that utilize the hospitals more than Mecklenburg, be recruited to be pilots in order to help contribute to the solution of high utilization.

Next, Tom Galligan, Deputy Director for Budget and Finance for the Division of Medical Assistance gave an update on community support services. (See Attachment No. 3) Mr. Galligan began by giving an update to the community support expenditures chart that he provided at the November LOC meeting. In November of FY 2007-08 the expenditure had grown to $166 million from November of FY 2006-07. He explained that there were 42 check-writes a year, and that there were variations in any given month between the number of check-writes, and the number of days that are in those check-writes. He said that when analyzing trends, DMA used a rolling 3 month average to compare data. DMA found that the expenditure rate for community support services was running about $80 million per month. He said that he felt that growth had been arrested in community support expenditures. He added that $66-$67 million had been budgeted per month for community support. The projected annual increase for community support when the service first started was $55 million. Mr. Galligan said the funds represented in his charts were a total of State and federal dollars. It was established that the service began in April of 2006, and was budgeted at $55 million per year, but has grown to $1 billion per year.

Senator Nesbitt told members that the Program Evaluation Division had met and had planned to study *Enhanced Mental Health and Substance Abuse Services* during the next long session, but instead decided to study the project during the short session in May 2008 to address the shortfall. Senator Nesbitt expressed concern that the program was killing the entire effort to resolve the mental health crisis. He said that there was no oversight in the program; the same person did the evaluation, wrote the plan, and treated the patient, and then sent the bill to Value Options. He said that $300 million had disappeared that was desperately needed for non-Medicaid patients. Members said that it

needed to be determined who was accountable, exactly what the problem was, how much money was needed to fix the problem, and then spend the money to fix the problem.

Secretary Dempsey Benton of the Department of Health and Human Services said that there were proposed changes in the system to raise the qualification standards for providers in order to improve services as well as other changes that would allow for some moderation in cost. He also said that the LMEs are in the process of renewing the endorsement for private providers which will improve the oversight and quality of the providers.

Due to time constraints, Representative Insko asked members to review the remainder of the community support handout on their own. She then asked Andrea Poole from Fiscal Research to review the FY 2007-08 LME service dollars allocation. (See Attachment No. 4) Ms. Poole explained that there were three key actions that the General Assembly passed in the budget that made the allocation of service dollars more complicated than usual. First, there was a realignment of services dollars unspent in FY 2006-07; second, the LME administrative cost model needed to be fully funded within the Department's existing budget; and third, the General Assembly directed that the LMEs had to receive as much in service dollars as was spent in FY 2006-07. Ultimately, the Division had to find $20 million within existing funds to fully fund the LME administrative cost model, and funds that might have been used in the past had either been moved or reduced.

Leza Wainwright, Deputy Director of the Division of MHDDSAS, addressed the allocation of community based service funds. (See Attachment No. 5) She said that there were two sources of funds that the Division could draw from - continuation funds and expansion funds. She explained that the Division identified the $20 million that needed to be realigned and taken out of continuation funds, and added to the expansion funds. Ms. Wainwright then explained how the continuation funds were allocated, and briefly reviewed the allocation chart and the utilization methodology chart.

After lunch, Kory Goldsmith reviewed a packet of information gathered in response to requests from the November 15th meeting. (See Attachment No. 6) She reviewed a chart responding to questions regarding utilized bed days, and a chart showing the type of admissions by LME, total admission numbers, and the rate. She also referenced information regarding the psychiatrist vacancy rates at each hospital, and a chart showing how the LMEs spent the funds allocated for psychiatrists. Finally, information was provided regarding the availability of psychiatrists (rural verses urban) across the state. Additional information was added to the packet addressing a question at the last meeting regarding how Value Options was paid.

Mike Moseley, Director of the Division of MHDDSAS, and Leza Wainwright, Deputy Director of the Division, addressed the revised plan for the closure of Dorothea Dix and John Umstead hospitals. (See Attachment No. 7) Mr. Moseley recognized Joe Bryan, Wake County Commissioner; David Cooke, Wake County Manager; and Joe Durham, Assistant County Manager. Mr. Moseley explained that a draft report was presented to the LOC in September, and that according to legislation, comments received during that presentation were used to develop the final plan. He said that there were several aspects

of the transition that would begin as early as this week. For example, letters were to go out to families and guardians of consumers on the long-term units, an executive team would be available on-site to answer questions, packets of information would be available to new admissions, and in February, Central Regional Hospital (CRH) would begin to accept adult admissions.

Mr. Moseley then reviewed the timeline for the transition to the new hospital, and the sequence for moving patients over an eleven day period in February. He explained that the new hospital would have 468 beds, and that additional beds were to be added to the R.J. Blackley ADATC unit. He also said that negotiations were underway with Wake County to develop a unit on the Dix campus that would operate for 2-3 years until Wake County could build community capacity. Wake County would finance a 24 bed unit, and the State would add up to 36 additional beds, for a total of 60 beds. The 24 bed unit would be operational by March 1, 2008.

Leza Wainwright addressed changes in population resulting from the change from 4 to 3 regions, and issues related to community capacity. She explained how moving to a 3 region model would decease the population by 20% at CRH. She said that all the ADATCs where increasing capacity, and that 3 of the hospitals had contracts with community hospitals for diversion beds. John Umstead is currently working on details of a diversion contract. Ms. Wainwright added that pending recertification of Broughton hospital, 50 additional forensic beds would be added. CRH would have 87 pre-trial/forensic beds. She went on to explain community capacity in the Central Region and in other parts of the State.

Representative Deborah Ross pointed out gaps in the revised report and gaps in compliance with State law. She said that there was no assessment of need to determine if capacity at CRH would meet the need. She asked what would be the quality of the capacity at Broughton, if it is recertified, considering there is a delay in admissions 50% of the time. She questioned when the hospital was expected to be recertified. Mike Moseley said that the Division was preparing a request for recertification from CMS on Broughton hospital as soon as possible. He said it could take a minimum of 30 days to a maximum of 120 days. Representative Ross added that the report on recruitment and retention was contradictory. The report states that they will be able to recruit and retain people, but then says that certain people do not want to move from urban areas into rural areas. Finally, she pointed out that there was not adequate information in the report about discharged patients, and the replacement services for children and adolescents would not be as good as what was being received now.

Members were also concerned that the number of beds for the hospitals was incorrect. It was suggested that before Dorothea Dix and John Umstead hospitals were closed, that CRH open and see that the other hospitals are operating at capacity to see that beds are not cut short. It was also suggested that staff capacity does not equal bed capacity, and if staffing shortages are a concern, would incentives be needed to bring in adequate staff; and how much money is expected for that expense. It was also mentioned that before

closing beds, there should be proof that the pilot program really reduces admissions to the hospitals.

Members also questioned how much county and State funds would go into the new Wake County facility. Information was requested on what the top 10 LME users of State beds are doing to reduce utilization, based on per capita. Members requested to know how much State money was provided to Mecklenburg County when that program was first started.

Representative Insko then called on members of the audience who wished to address the committee to come forward with their comments. Items of concern were: concern over the closure of Dix/Umstead hospitals - unrealistic timeframe of move, staffing issues; funding needed for therapeutic treatment for substance abusers; more attention to prevention for substance abuse; support for recruitment and retention of prevention efforts and programs; tuition assistance programs for those studying in the prevention field; capacity to support substance abuse professionals in all communities including rural area; concern over cuts of vacant positions in State facilities – who will assist non ambulatory and ambulation challenges, those with modified diets, change those in adult diapers in a timely manner, or those bedridden who could develop bed sores; concern that State buildings are on Wake County property without contributing to tax base; concern over mentally ill in homeless shelters – 34 died from sleeping outside last year in the Triangle area; community support - conflict of interest when providers assess and provide services; let only LMEs provide assessments; request data on how many providers assess and then provide services; correct service definition to reflect who decides who gets what; complaints against Implementation #35 discriminates against consumer forcing loved ones out of their homes and into institutions; support of proposal for the Dix hospital to remain open and provide services for mental health as long as needed; and keep 32 beds or more until 2011 or longer if needed.

There being no further business, the meeting adjourned at 3:10 PM.

_____	_____
Senator Martin Nesbitt, Co-Chair	Representative Verla Insko, Co-Chair

_____

Rennie Hobby, Committee Assistant